CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 20:010[~~907 KAR 1:605~~]. Medicaid procedures for determining initial and continuing eligibility other than procedures related to a modified adjusted gross income eligibility standard or related to former foster care individuals.

RELATES TO: KRS 205.520, 42 C.F.R. 435.530, 435.531, 435.540, 435.541, 435.914, 435.916, 42 U.S.C. 416, 1382, 1396a, b, d

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 U.S.C. 1396a[~~, EO 2004-726~~]

NECESSITY, FUNCTION, AND CONFORMITY: [~~EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.~~] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes provisions relating to determining initial and continuing eligibility for assistance under the Medicaid Program except for individuals for whom a

modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals who aged out of foster care while receiving Medicaid coverage.

Section 1. [~~Definition. (1) "Department" means the Department for Medicaid Services or its designee.~~

~~(2) "First month of SSI payment" means the first month for which an SSI-related Medicaid recipient is determined to be eligible for SSI payments.~~

~~(3) "Partnership" means an entity that meets the criteria established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver), Section 5, and, under contract with the department in accordance with KRS Chapter 45A, agrees to provide, or arrange for the provision of, health services to members on the basis of prepaid capitation payments.~~

~~Section 2.~~] Eligibility Determination Process. (1)(a) Except as provided in subsection (3) or (5) of this section, eligibility shall be determined prospectively.

(b) To receive or continue to receive assistance, a household shall meet technical and financial eligibility criteria, for the appropriate month of coverage, pursuant to:

1. This section;

2. [~~and~~] Section 3 of this administrative regulation; and

3. As established in:

a. 907 KAR 20:005;

b. 907 KAR 20:020; and

c. 907 KAR 20:025[~~the following administrative regulations for the appropriate month of coverage:~~

~~a. 907 KAR 1:011, Technical eligibility requirements;~~

~~b. 907 KAR 1:640, Income standards for Medicad; and~~

~~c. 907 KAR 1:645, Resource standards for Medicaid~~].

(2) A decision regarding eligibility or ineligibility for Medicaid shall be supported by facts recorded in the case record.

(a) The applicant or recipient shall be the primary source of information and shall:

1. Furnish verification of financial and technical eligibility as required by 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025[~~the following administrative regulations:~~

~~a. 907 KAR 1:011, Technical eligibility requirements for Medicaid;~~

~~b. 907 KAR 1:640, Income standards for Medicaid; and~~

~~c. 907 KAR 1:645, Resource standards for Medicaid~~]; and

2. Give written consent to those contacts necessary to verify or clarify a factor pertinent to the decision of eligibility.

(b)1. The department may schedule an appointment with an applicant or recipient to receive specified information as proof of eligibility.

2. Failure to appear for the scheduled appointment or to furnish the requested information shall be considered a failure to present adequate proof of eligibility if the applicant or recipient was informed in writing of the scheduled appointment and the required information.

(3) Retroactive eligibility for Medicaid not related to the receipt of SSI benefits shall be effective no earlier than the third month prior to the month of application if:

(a) A Medicaid service was received;

(b) Technical and financial eligibility requirements were met as established in 907

KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025[~~the following administrative regulations:~~

~~a. 907 KAR 1:011, Technical eligibility requirements for Medicaid;~~

~~b. 907 KAR 1:640, Income standards for Medicaid; and~~

~~c. 907 KAR 1:645, Resource standards for Medicaid~~]; and

(c)[~~1.~~] The applicant is excluded from managed care organization participation in accordance with 907 KAR 17:010[~~resides in a nonpartnership county; or~~

~~2. The applicant resides in a county served by a partnership and meets one (1) of the excluded categories as established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver)~~].

(4) Eligibility for qualified Medicare beneficiary [~~(QMB)~~] coverage shall be effective the month after the month of case approval if technical and financial eligibility requirements were met as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025[~~the following administrative regulations:~~

~~a. 907 KAR 1:011, Technical eligibility requirements for Medicaid;~~

~~b. 907 KAR 1:640, Income standards for Medicaid; and~~

~~c. 907 KAR 1:645, Resource standards for Medicaid~~].

(5)[~~(a)~~] Retroactive eligibility for specified low-income Medicare beneficiary [~~(SLMB)~~] benefits, Medicare qualified individual group 1 (QI-1)[~~individuals (QI)~~] benefits, or qualified disabled and working individuals shall be effective no earlier than the third month prior to the month of application if the[~~an~~] individual meets technical and financial eligibility requirements as established in 907 KAR 20:005, 907 KAR 20:020, and 907 KAR 20:025[~~the following administrative regulations:~~

~~a. 907 KAR 1:011, Technical eligibility requirements for Medicaid;~~

~~b. 907 KAR 1:640, Income standards for Medicaid; and~~

~~c. 907 KAR 1:645, Resource standards for Medicaid.~~

~~(b) Retroactive eligibility for a qualified individual shall not include months of a prior year~~].

(6) An SSI-related recipient[~~age twenty-one (21) or older~~], in accordance with HCFA Program Issuance Transmittal Notice, Region IV, May 7, 1997, MCD-014-97, shall be eligible for Medicaid benefits effective the month prior to the first month of SSI payment if the individual[~~recipient~~]:

(a) Is eligible to be enrolled with a managed care organization in accordance with 907 KAR 17:010[~~Resides in a partnership county~~]; and

(b) Meets Medicaid eligibility requirements for that month.

(7) An SSI-related recipient, in accordance with HCFA Program Issuance Transmittal Notice, Region IV, May 7, 1997, MCD-014-97, shall be retroactively eligible for Medicaid benefits effective no earlier than the third month prior to the first month of SSI payment if the individual[~~recipient~~]:

(a) Is excluded from managed care organization participation in accordance with 907 KAR 17:010[~~(a)1. Resides in a nonpartnership county~~]; and

(b)[~~2.~~] Meets Medicaid eligibility requirements for these months[~~; or~~

~~(b)1. Resides in a partnership county; and~~

~~2. Meets the requirements for one (1) of the excluded categories established in 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver).~~

~~(8) For an SSI recipient under age twenty-one (21), Medicaid coverage shall:~~

~~(a) Automatically begin with the month prior to the first month of SSI payment; and~~

~~(b) Be available for the three (3) preceding months if the recipient meets Medicaid eligibility requirements for those three months~~].

Section 2.[~~3.~~] Continuing Eligibility. (1)The[~~A~~] recipient shall be responsible for reporting within ten (10) days a change in circumstances which may affect eligibility.

(2) [~~In addition,~~] Eligibility shall be redetermined:

(a) Every twelve (12) months; or

(b) If a report is received or information is obtained about a change in circumstances.

[~~(2) Pursuant to the waiver granted by the Secretary, United States Department of Health and Human Services, and promulgated as 907 KAR 1:705, Demonstration project: services provided through regional managed care partnerships (1115 Waiver), a recipient shall have a one (1) time guarantee of six (6) months of eligibility regardless of a loss of technical eligibility for Medicaid during that six (6) month time period if the recipient:~~

~~(a) Resides in a county included in a partnership;~~

~~(b) Did not meet one (1) of the excluded categories established in 907 KAR 1:705;~~

~~(c) Did not receive Medicaid in any of the twelve (12) months preceding participation in a partnership;~~

~~(d) Participated in a partnership for less than six (6) months;~~

~~(e) Continued to reside in a partnership region during the guaranteed six (6) month eligibility period; and~~

~~(f) Is not an:~~

~~1. Incarcerated recipient;~~

~~2. Alien who is eligible for emergency Medicaid; or~~

~~3. A recipient requesting discontinuance of Medicaid.~~]

Section 3.[~~4.~~] Determination of Incapacity or Permanent and Total Disability. (1) Except as provided in subsections (2) and (3) of this section, a determination that a parent with whom the needy child lives is incapacitated, or that the individual requesting Medicaid due to disability is both permanently and totally disabled, shall be made by the medical review team following review of both medical and social reports.

(2) A parent shall be considered incapacitated without a determination from the medical review team if:

(a) The parent declares physical inability to work;

(b) The worker observes some physical or mental limitation; and

(c) The parent:

1. Is receiving SSI benefits[~~supplemental security income (SSI)~~];

2. Is age sixty-five (65) years or over;

3. Has been determined to meet the definition of blindness or permanent and total disability as contained in 42 U.S.C. 1382 or 416 by either the Social Security Administration or the medical review team;

4.a. Has previously been determined to be incapacitated or both permanently and totally disabled by the medical review team, hearing officer, appeal board, or court of proper jurisdiction without a reexamination requested; and

b. There is no visible improvement in condition;

5. Is receiving Retirement, Survivors, and Disability Insurance [~~(RSDI)~~] benefits, federal black lung benefits, or railroad retirement benefits based on disability as evidenced by an award letter;

6. Is receiving Veterans Affairs[~~Administration (VA)~~] benefits based on 100 percent disability, as verified by an award letter; or

7.a. Is currently hospitalized and a statement from the attending physician indicates that incapacity will continue for at least thirty (30) days.

b. If application was made prior to the admission, the physician shall indicate if incapacity existed as of the application date.

(3) An individual shall be considered permanently and totally disabled without a determination from the medical review team if the individual:

(a) Receives RSDI or railroad retirement benefits based on disability;

(b) Received SSI benefits based on disability during a portion of the twelve (12) months preceding the application month and discontinuance was due to income or resources and[~~,~~] not to improvement in physical condition;

(c) Has been determined to meet the definition of blindness or both permanent and total disability as contained in 42 U.S.C. 416 or 1382 by the Social Security Administration; or

(d)1. Has previously been determined to be permanently and totally disabled by the medical review team, hearing officer, appeal board, or court of proper jurisdiction without a reexamination requested; and

2. There is no visible improvement in condition.

(4)(a) A child who was receiving SSI[~~supplemental security income~~] benefits on

August 22, 1996 and who, but for the change in definition of childhood disability established by 42 U.S.C. 1396a(a)(10) would continue to receive SSI benefits, shall continue to meet the Medicaid definition of disability.

(b) If a redetermination is necessary, and in accordance with 921 KAR 5:470, the definition of childhood disability effective on August 22, 1996 shall be used.

Section 4.[~~5.~~] Disqualification. An adult individual shall be disqualified from receiving Medicaid for a specified period of time if the department or a court determines the individual has committed an intentional program violation in accordance with 907 KAR 1:675.

Section 5. Applicability. **[~~(1)~~]** The provisions and requirements of this administrative regulation shall not apply to an individual**[~~:~~**

~~(a)~~] whose Medicaid eligibility is determined**:**

(1) Using the modified adjusted gross income as the income standard **pursuant to 907 KAR 20:100**; or

(2) Pursuant to 907 KAR 20:075[~~(b) Between the ages of nineteen (19) and twenty-six (26) years who:~~

~~1. Formerly was in foster care; and~~

~~2. Aged out of foster care while receiving Medicaid coverage.~~

~~(2) An individual whose Medicaid eligibility is determined using the modified adjusted gross income as an income standard shall be an individual who is:~~

~~(a) A child under the age of nineteen (19) years, excluding children in foster care;~~

~~(b) A caretaker relative with income up to 133 percent of the federal poverty~~

~~level;~~

~~(c) A pregnant woman, with income up to 185 percent of the federal poverty level, including the postpartum period up to sixty (60) days after delivery;~~

~~(d) An adult under age sixty-five (65) with income up to 133 percent of the federal poverty level who:~~

~~1. Does not have a dependent child under the age of nineteen (19) years; and~~

~~2. Is not otherwise eligible for Medicaid benefits; or~~

~~(e) A targeted low income child with income up to 150 percent of the federal poverty level~~].

Section 6. Incorporation by Reference. (1) "HCFA Program Issuance Transmittal Notice Region IV", May 7, 1997, MCD-014-97, is incorporated by reference.

(2) This material may be:

(a) Inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m.; or

(b) Viewed at http://www.chfs.ky.gov/dms/incorporated.htm.

907 KAR 20:010

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 907 KAR 20:010
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of authorizing statutes by establishing Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statutes by establishing Medicaid program policies and requirements regarding covered services hearings and appeals for the Medicaid population.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment establishes that the eligibility determination procedures do not apply to individuals for whom a modified adjusted gross income (or MAGI) is the income eligibility standard or to former foster care individuals who aged out of foster care while receiving Medicaid coverage; removes definitions from the administrative regulation as those are now being established in a definitions administrative regulation for all administrative regulations within the new chapter – Chapter 20 – which will house Medicaid eligibility administrative regulations; and contains language and formatting revisions to comply with KRS Chapter 13A as this administrative regulation has not been amended since 1993. Individuals for whom a MAGI is the Medicaid income eligibility standard are children under nineteen (19) – except for children in foster care; caretaker relatives with income up to 133 percent of the federal poverty level; pregnant women [including through day sixty (60) of the postpartum period] with income up to 185 percent of the federal poverty level; adults under sixty-five (65) with no child under nineteen (19) who do not otherwise qualify for Medicaid and whose income is below 133 percent of the federal poverty level; and targeted low-income children with income up to 150 percent of the federal poverty level. The amendment after comments rewords the section which

establishes to which eligibility groups the provisions of this administrative regulation apply to simply refer to the other relevant administrative regulations.

(b) The necessity of the amendment to this administrative regulation: The amendment exempting MAGI individuals and former foster care individuals from the requirement are necessary to comply with Affordable Care Act mandates. Eliminating the definitions from the administrative regulation is necessary as the Department for Medicaid Services is creating a definitions administrative regulation (907 KAR 20:001) for Chapter 20; and other amendments are necessary to ensure compliance with KRS Chapter 13A language and formatting requirements.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment conforms to the content of the authorizing statutes by complying with Affordable Care Act mandates, by clarifying policy, and by revising language and formatting to ensure that it complies with KRS Chapter 13A standards.

(d) How the amendment will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the authorizing statues by complying with Affordable Care Act mandates, by clarifying policy, and by revising language and formatting to ensure that it complies with KRS Chapter 13A standards.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Individuals whose Medicaid income eligibility standard is a modified adjusted gross income will be affected by the amendment as they are exempted from the requirements in this administrative regulation. The Department for Medicaid Services (DMS) estimates that the affected group will encompass 678,000 individuals in state fiscal year (SFY) 2014. Additionally, the requirements do not apply to former foster care individuals who aged out foster care while receiving Medicaid benefits at the time. DMS estimates that this group will include 3,358 individuals.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: A recipient who wishes to appeal a Medicaid service denial shall comply with the appeal provisions established in this administrative regulation.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3): No cost is imposed by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3): Individuals who are exempted from the requirements will benefit from not being subject to the requirements for Medicaid eligibility purposes.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: DMS anticipates no cost as a result of exempting the MAGI individuals or former foster care individuals from the requirements in this administrative regulation.

(b) On a continuing basis: The answer provided in paragraph (a) also applies here

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Sources of funding to be used for the implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX and Title XXI of the Social Security Act, and state matching funds of general and agency appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: This administrative regulation does not impose or increase any fees.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: The amendment does not establish or increase any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is only applied in that the provisions do not apply to individuals for whom a modified adjusted gross income is the Medicaid eligibility income standard or former foster care individuals as the Affordable Care Act prohibits this.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 20:010
Contact Person: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 435.906 and this administrative regulation authorize the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS does not expect the amendment to this administrative regulation to generate revenue for state or local government.
   (c) How much will it cost to administer this program for the first year? DMS anticipates no cost in the first year as a result of exempting the individuals for whom a modified adjusted gross income is the Medicaid eligibility standard from the income standards established in this administrative regulation nor from exempting former foster care individuals from the standards.
   (d) How much will it cost to administer this program for subsequent years? DMS anticipates no cost in subsequent years as a result of exempting the MAGI individuals from the income standards established in this administrative regulation nor from exempting the former foster care individuals from the income standards.

   Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

   Revenues (+/-): ____
   Expenditures (+/-): ____
   Other Explanation: No additional expenditures are necessary to implement this amendment.

FEDERAL MANDATE ANALYSIS COMPARISON

Regulation Number: 907 KAR 20:010
Contact Person: Marchetta Carmicle (502) 564-6204 or Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(e)(14) and 42 U.S.C. 1396a(a)(10)(A)(i)(IX).

2. State compliance standards. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with a requirement that may be imposed or opportunity presented by federal law for the provision of medical assistance to Kentucky's indigent citizenry.

   KRS 194A.050(1) requires the cabinet secretary to "formulate, promote, establish, and execute policies, plans, and programs and shall adopt, administer, and enforce throughout the commonwealth all applicable state laws and all administrative regulations necessary under applicable state laws to protect, develop, and maintain the health, personal dignity, integrity, and sufficiency of the individual citizens of the commonwealth and necessary to operate the programs and fulfill the responsibilities vested in the cabinet. The secretary shall promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs."

3. Minimum or uniform standards contained in the federal mandate. Effective January 1, 2014, each state's Medicaid program is required – except for certain designated populations - to determine Medicaid eligibility by using the modified adjusted gross income and is prohibited from using any type of expense, income disregard, or any asset or resource test. The populations exempted from the new requirements (and to whom the old requirements continue to apply) include aged individuals [individuals over sixty-five (65) years of age or who receive Social Security Disability Insurance; individuals eligible for Medicaid as a result of being a child in foster care; individuals who are blind or disabled; individuals who are eligible for Medicaid via another program; individuals enrolled in a Medicare savings program; and medically needy individuals.

   42 U.S.C. 1396a(a)(10)(A)(i)(IX) creates the new eligibility group comprised of former foster care individuals and bars the application of certain existing Medicaid eligibility requirements to this population.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? This amendment does not impose stricter, than federal, requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. This amendment does not impose stricter, than federal, requirements.